STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	003563	A. BUILDING: _____ B. WING _____	R 01/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HEALTHSET	955D S HEBRON AVE EVANSVILLE, IN 47714

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{N 000}	Initial Comments This was a revisit for the State re-licensure survey completed on 9-15-15, 9-16-15, 9-17-15, & 9-18-15. Survey Date: 1-4-16 Facility #: 003563 Medicare Provider #: 15-7559 Medicaid Vendor #: 200450280 Census: 4 skilled patients 3 home health aide only patients 7 total patients	{N 000}		
{N 504}	410 IAC 17-12-3(b)(2)(D)(i) Patient Rights Rule 12 (b) The patient has the right to exercise his or her rights as a patient of the home health agency as follows: (2) The patient has the right to the following: (D) Be informed about the care to be furnished, and of any changes in the care to be furnished as follows: (i) The home health agency shall advise the patient in advance of the: (AA) disciplines that will furnish care; and (BB) frequency of visits proposed to be furnished. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure patients had been informed of the frequency of skilled nursing and home health aide visits proposed to be furnished in 3 (#s 1, 2, and 3) of 3 records reviewed. The findings include:	{N 504}		

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{N 504}	Continued From page 1 1. Clinical record number 1 included a "Patient Authorization", signed and dated by the patient's parent on 9-30-15, that indicated skilled nursing would be provided 3 times per week and home health aide services would be provided 1 time per week. The authorization failed to evidence the patient's parent had been informed of the frequency of skilled nursing visits ordered by the physician. The record included a plan of care established by the physician for the certification period 11-17-15 to 1-15-16 that evidenced skilled nursing had been ordered 2 times per week for 1 week, 3 times per week for 4 weeks, 2 times per week for 3 weeks, and 3 times per week for 1 week. 2. Clinical record number 2 included a "Patient Authorization" signed and dated by the patient on 12-16-15. The authorization failed to evidence the frequency of home health aide visits to be provided. The record included a plan of care established by the physician for the certification period 12-10-15 to 2-7-16 that evidenced home health aide services had been ordered 5 times per week for 1 week 8 times per week for 1 week, 4 times per week for 1 week, and 6 times per week for 6 weeks. 3. Clinical record number 3 included a "Patient Authorization" signed and dated by the patient on 10-22-15. The authorization indicated skilled nursing would be provided 3 times per week, home health aide services 2 times per week, and attendant care services 1 time per week.	{N 504}		

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{N 504}	Continued From page 2 A. The record included a plan of care established by the physician for the certification period 10-22-15 to 12-20-15 that evidenced skilled nursing had been ordered 1 time per week for 1 week, 3 times per week for 3 weeks, and 2 times per week for 5 weeks. The plan of care evidenced home health aide services had been ordered 1 time per week for 1 week and 2 times per week for 8 weeks. B. The record included a plan of care established by the physician for the certification period 12-21-15 to -18-15 that evidenced skilled nursing had been ordered 2 times per week for 2 weeks and 3 times per week for 7 weeks. 4. The Administrator was unable to provide any additional documentation and/or information when asked on 1-4-16 at 3:00 PM. 5. The agency's undated "Client Rights" policy number II-17 states, "The agency shall advise the client in advance of the disciplines that will furnish care, and the frequency of visits proposed to be furnished."	{N 504}		
{N 522}	410 IAC 17-13-1(a) Patient Care Rule 13 Sec. 1(a) Medical care shall follow a written medical plan of care established and periodically reviewed by the physician, dentist, chiropractor, optometrist or podiatrist, as follows: This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure medications, treatments, and services had been provided as ordered by the	{N 522}		

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{N 522}	Continued From page 3 physician in 3 (#s 1, 2, and 3) of 3 records reviewed. The findings include: 1. Clinical record number 1 identified the patient as a 14 year old pediatric patient with Hunter's Syndrome, a genetic disease that can affect all parts of the body, including the brain. The record failed to evidence medications and treatments had been administered as ordered by the physician on the plan of care. The record included a plan of care established by the physician for the certification period 11-17-15 to 1-15-16. The plan of care states, "SN [skilled nurse] to instruct PCG [patient caregiver] to administer Benadryl 25 mg [milligrams] via G-tube [gastrostomy tube] 30 to 60 minutes prior to infusion. SN to apply or instruct PCG to apply Emla cream [numbing medication] or LMX4 [?] cream one hour prior to accessing port . . . SN to flush IV [intravenous] line with 25 ml [milliliters] NaCl [sodium chloride] at 40 ml per hour post infusion then flush line with 10 ml NS [normal saline], then 5 ml heparin, and deaccess port [remove needle]." A. A SN visit note dated 11-20-15 evidenced the Benadryl and numbing cream had been administered at 3:05 PM and that the port had been accessed at 3:35 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port per the physician's order. B. A SN visit note dated 11-25-15 evidenced the Benadryl and numbing cream had been administered at 4:35 PM and the port had been accessed at 5:10 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior	{N 522}		

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{N 522}	Continued From page 4	{N 522}		

to accessing the port per the physician's order.

The note failed to evidence the IV line had been flushed after the infusion had been completed in accordance with the physician's order. The note states, "Infusion finished at 2150 [9:50 PM]. Flushed with 5 ml heparin port deaccessed at 2151." The note failed to evidence the IV line had been flushed with normal saline per the physician's orders.

C. A SN visit note dated 12-1-15 evidenced the Benadryl and numbing cream had been administered at 4:20 PM and the port accessed at 4:55 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port.

D. A SN visit note dated 12-8-15 evidenced the Benadryl and numbing cream had been administered at 3:35 PM and the port accessed at 4:05 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port.

The note failed to evidence the IV line had been flushed after the infusion had been completed in accordance with physician orders.

E. A SN visit note dated 12-15-15 evidenced the Benadryl and numbing cream had been administered at 4:55 PM and port accessed at 5:35 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port.

The note failed to evidence the IV line had been flushed with normal saline as ordered at the completion of the infusion. The note states, "Infusion complete at 2210 [10:10 PM]. Flushed

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{N 522}	Continued From page 5	{N 522}		

[with] 5 ml heparin. Deaccessed at 2212."

F. A SN visit note dated 12-22-15 evidenced the Benadryl and numbing cream had been administered at 3:35 PM and the port accessed at 3:35 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port.

The note failed to evidence the IV line had been flushed with normal saline as ordered at the completion of the infusion. The note states, "Infusion completed. Flushed with 5 ml heparin. Port deaccessed."

G. A SN visit note dated 12-29-15 evidenced the Benadryl and numbing cream had been administered at 7:40 AM and port had been accessed at 8:15 AM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port.

The note failed to evidence the IV line had been flushed with normal saline as ordered at the completion of the infusion. The note states, "Infusion finished. Flushed port with 5 ml heparin. Deaccessed port."

H. The plan of care included an order for the skilled nurse to "perform vest treatment per order." (A respiratory vest is a garment that rapidly inflates and deflates around the wearer and is used to break up mucous and secretions in the lungs.)

SN visit notes, dated 11-18-15, 11-20-15, 11-23-15, 11-25-15, 11-27-15, 11-30-15, 12-1-15, 12-2-15, 12-7-15, 12-8-15, 12-11-15, 12-14-15, 12-15-15, 12-16-15, 12-21-15, 12-22-15, 12-28-15, and 12-29-15, failed to evidence the

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{N 522}	Continued From page 6 SN had performed the vest therapy. 2. Clinical record number 2 included a plan of care established by the physician for the certification period 12-10-15 to 2-7-16. The plan of care indicated home health aide services were to be provided 5 times per week for 1 week, 8 times per week for 1 week, 4 times per week for 1 week and 6 times per week for 6 weeks. The plan of care included orders for the skilled nurse (SN) to "perform dressing changes 3 times a week" to the left ischum [sic] and cocyx [sic]. The wound care orders state, "Cleanse wound beds with saline wound cleanser soaked 4 x 4s, using sterile Q-tips apply Santyl to wound beds and pack with 4 x 4s and Kerlix. Using sterile Q-tips, apply Calmoseptine ointment around wound edges and apply skin prep to outer skin areas cover wounds with ABD pads and secure with tape." A. A verbal physician order dated 12-16-15 evidenced silver dressing was to be applied to the wound bed in place of the Santyl. B. The record evidenced home health aide visits had been provided only 4 times per week the second week and only 2 times per week the third and fourth weeks, instead of 8 times per week as ordered by the physician. C. A SN visit note dated 12-18-15 failed to evidence the SN had applied the Calmoseptine ointment around the wound edges as ordered by the physician. D. A SN visit note dated 12-24-15 failed to evidence the SN had applied the silver dressing to the wound bed as ordered by the physician.	{N 522}		

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{N 522}	Continued From page 7 3. Clinical record number 3 identified the patient as a 69 year old with diagnoses of open wounds of the right forearm and right leg, COPD (chronic obstructive pulmonary disease), and congestive heart failure. The record included plans of care established by the physician for the certification periods 10-22-15 to 12-20-15 and 12-21-15 to 2-18-16. The plans of care state, "SN to obtain weight once a week and notify MD of a gain or loss of 2 lbs within a week. SN to do dressing change to Rt [right] lower leg, Lt [left] lower leg, Lt forearm, Rt forearm wounds." A. SN visit notes, dated 12-2-15, 12-4-15, 12-7-15, 12-9-15, 12-11-15, 12-14-15, 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence the SN had obtained the patient's weight at any of the visits. B. SN visit notes, dated 12-2-15, 12-4-15, 12-7-15, 12-9-15, 12-11-15, 12-14-15, 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence any wound care had been provided to the patient's left lower leg. 4. The administrator was unable to provide any additional documentation and/or information when asked on 1-4-16 at 3:00 PM. 5. The agency's undated "Physician's Plan of Treatment (Care)/Change Orders" policy number III-19 states, "The Agency will provide care/services consistent with the plan of care."	{N 522}		
{N 524}	410 IAC 17-13-1(a)(1) Patient Care Rule 13 Sec. 1(a)(1) As follows, the medical plan of care shall: (A) Be developed in consultation with the home	{N 524}		

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{N 524}	Continued From page 8 health agency staff. (B) Include all services to be provided if a skilled service is being provided. (B) Cover all pertinent diagnoses. (C) Include the following: (i) Mental status. (ii) Types of services and equipment required. (iii) Frequency and duration of visits. (iv) Prognosis. (v) Rehabilitation potential. (vi) Functional limitations. (vii) Activities permitted. (viii) Nutritional requirements. (ix) Medications and treatments. (x) Any safety measures to protect against injury. (xi) Instructions for timely discharge or referral. (xii) Therapy modalities specifying length of treatment. (xiii) Any other appropriate items. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure plans of care included individualized and specific orders for treatments in 2 (#s 1 and 3) of 3 records reviewed. The findings include: 1. Clinical record number 1 included a plan of care established by the physician for the certification period 11-17-15 to 1-15-16. The plan of care included an order for the skilled nurse to "perform vest treatment per order." (A respiratory vest is a garment that rapidly inflates and deflates around the wearer and is used to break up mucous and secretions in the lungs.) The plan of care failed to include specific orders related to the	{N 524}		

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{N 524}	Continued From page 9 use of the respiratory vest. The plan of care included an order for heparin to be used as a flush after the infusion of an intravenous medication. The plan of care states, "Heparin 5 ml [milliliter] IV [intravenous] post infusion following 10 cc [cubic centimeters] flush of 0.9% NaCl [sodium chloride]. The order failed to include the specific strength (number of units per milliliter) of the heparin. 2. Clinical record number 3 identified the patient as a 69 year old with diagnoses of open wounds of the right forearm and right leg, COPD (chronic obstructive pulmonary disease), and congestive heart failure. The record included a plan of care established by the physician for the certification period 12-21-15 to 2-18-16. The plan of care states, "SN to do dressing change to Rt [right] lower leg, Lt [left] lower leg, Lt forearm, Rt forearm wounds." A. The follow-up comprehensive assessment dated 12-16-15 failed to evidence an assessment of a wound on the patient's left leg. B. SN visit notes, dated 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence any wound care had been provided to the patient's left lower leg. 3. The administrator was unable to provide any additional documentation and/or information when asked on 1-4-16 at 3:00 PM. 4. The agency's undated "Physician's Plan of Treatment (Care)/Change Orders" policy number III-19 states, "The physician's plan of treatment (Medical Plan of Care) is an individualized plan for care treatment prepared by the client's	{N 524}		

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{N 524}	Continued From page 10 physician with assistance from the nurse and/or therapist who establish the plan based upon the current assessment of the client . . . Physician's orders on the plan of treatment shall relate to the diagnosis and must be considered reasonable and necessary treatment for that diagnosis."	{N 524}		
N 527	410 IAC 17-13-1(a)(2) Patient Care Rule 13 Sec. 1.(a)(2) The health care professional staff of the home health agency shall promptly alert the person responsible for the medical component of the patient's care to any changes that suggest a need to alter the medical plan of care. This RULE is not met as evidenced by: Based on record review and interview, agency staff failed to notify the physician of a change in the patient's wound status in 1 (#3) of 3 records reviewed. The findings include: 1. Clinical record number 3 identified the patient as a 69 year old with diagnoses of open wounds of the right forearm and right leg, COPD (chronic obstructive pulmonary disease), and congestive heart failure. The record included a plan of care established by the physician for the certification period 12-21-15 to 2-18-16. The plan of care states, "SN to do dressing change to Rt [right] lower leg, Lt [left] lower leg, Lt forearm, Rt forearm wounds." A. The follow-up comprehensive assessment dated 12-16-15 failed to evidence an assessment of a wound on the patient's left leg.	N 527		

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N 527	Continued From page 11 B. SN visit notes, dated 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence any wound care had been provided to the patient's left lower leg. 2. The administrator stated, on 1-4-16 at 3:15 PM, "The wound [on the left leg] may have been healed." 3. The agency's undated "Physician's Plan of Treatment (Care)/Change Orders" policy number III-19 states, "The recertification of physician's order summary shall include: Changes in client's physical or psychosocial condition."	N 527		
{N 537}	410 IAC 17-14-1(a) Scope of Services Rule 1 Sec. 1(a) The home health agency shall provide nursing services by a registered nurse or a licensed practical nurse in accordance with the medical plan of care as follows: This RULE is not met as evidenced by: Based on record review and interview, the registered nurse failed to ensure medications, treatments, and services had been provided as ordered by the physician in 3 (#s 1, 2, and 3) of 3 records reviewed. The findings include: 1. Clinical record number 1 identified the patient as a 14 year old pediatric patient with Hunter's Syndrome, a genetic disease that can affect all parts of the body, including the brain. The record failed to evidence medications and treatments had been administered as ordered by the physician on the plan of care. The record	{N 537}		

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{N 537}	Continued From page 12	{N 537}		

included a plan of care established by the physician for the certification period 11-17-15 to 1-15-16. The plan of care states, "SN [skilled nurse] to instruct PCG [patient caregiver] to administer Benadryl 25 mg [milligrams] via G-tube [gastrostomy tube] 30 to 60 minutes prior to infusion. SN to apply or instruct PCG to apply Emla cream [numbing medication] or LMX4 [?] cream one hour prior to accessing port . . . SN to flush IV [intravenous] line with 25 ml [milliliters] NaCl [sodium chloride] at 40 ml per hour post infusion then flush line with 10 ml NS [normal saline], then 5 ml heparin, and deaccess port [remove needle]."

A. A SN visit note dated 11-20-15 evidenced the Benadryl and numbing cream had been administered at 3:05 PM and that the port had been accessed at 3:35 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port per the physician's order.

B. A SN visit note dated 11-25-15 evidenced the Benadryl and numbing cream had been administered at 4:35 PM and the port had been accessed at 5:10 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port per the physician's order.

The note failed to evidence the IV line had been flushed after the infusion had been completed in accordance with the physician's order. The note states, "Infusion finished at 2150 [9:50 PM]. Flushed with 5 ml heparin port deaccessed at 2151." The note failed to evidence the IV line had been flushed with normal saline per the physician's orders.

C. A SN visit note dated 12-1-15 evidenced

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{N 537}	Continued From page 13 the Benadryl and numbing cream had been administered at 4:20 PM and the port accessed at 4:55 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port. D. A SN visit note dated 12-8-15 evidenced the Benadryl and numbing cream had been administered at 3:35 PM and the port accessed at 4:05 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port. The note failed to evidence the IV line had been flushed after the infusion had been completed in accordance with physician orders. E. A SN visit note dated 12-15-15 evidenced the Benadryl and numbing cream had been administered at 4:55 PM and port accessed at 5:35 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port. The note failed to evidence the IV line had been flushed with normal saline as ordered at the completion of the infusion. The note states, "Infusion complete at 2210 [10:10 PM]. Flushed [with] 5 ml heparin. Deaccessed at 2212." F. A SN visit note dated 12-22-15 evidenced the Benadryl and numbing cream had been administered at 3:35 PM and the port accessed at 3:35 PM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port. The note failed to evidence the IV line had been flushed with normal saline as ordered at the completion of the infusion. The note states,	{N 537}		

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	003563	A. BUILDING: _____ B. WING _____	R 01/04/2016

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{N 537}	Continued From page 14 "Infusion completed. Flushed with 5 ml heparin. Port deaccessed." G. A SN visit note dated 12-29-15 evidenced the Benadryl and numbing cream had been administered at 7:40 AM and port had been accessed at 8:15 AM. The SN failed to ensure the numbing cream had been applied 1 hour prior to accessing the port. The note failed to evidence the IV line had been flushed with normal saline as ordered at the completion of the infusion. The note states, "Infusion finished. Flushed port with 5 ml heparin. Deaccessed port." H. The plan of care included an order for the skilled nurse to "perform vest treatment per order." (A respiratory vest is a garment that rapidly inflates and deflates around the wearer and is used to break up mucous and secretions in the lungs.) SN visit notes, dated 11-18-15, 11-20-15, 11-23-15, 11-25-15, 11-27-15, 11-30-15, 12-1-15, 12-2-15, 12-7-15, 12-8-15, 12-11-15, 12-14-15, 12-15-15, 12-16-15, 12-21-15, 12-22-15, 12-28-15, and 12-29-15, failed to evidence the SN had performed the vest therapy. 2. Clinical record number 2 included a plan of care established by the physician for the certification period 12-10-15 to 2-7-16. The plan of care indicated home health aide services were to be provided 5 times per week for 1 week, 8 times per week for 1 week, 4 times per week for 1 week and 6 times per week for 6 weeks. The plan of care included orders for the skilled nurse (SN) to "perform dressing changes 3 times a week" to the left ischum [sic] and cocyx [sic]. The	{N 537}		

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{N 537}	Continued From page 15 wound care orders state, "Cleanse wound beds with saline wound cleanser soaked 4 x 4s, using sterile Q-tips apply Santyl to wound beds and pack with 4 x 4s and Kerlix. Using sterile Q-tips, apply Calmoseptine ointment around wound edges and apply skin prep to outer skin areas cover wounds with ABD pads and secure with tape." A. A verbal physician order dated 12-16-15 evidenced silver dressing was to be applied to the wound bed in place of the Santyl. B. The record evidenced home health aide visits had been provided only 4 times per week the second week and only 2 times per week the third and fourth weeks, instead of 8 times per week as ordered by the physician. C. A SN visit note dated 12-18-15 failed to evidence the SN had applied the Calmoseptine ointment around the wound edges as ordered by the physician. D. A SN visit note dated 12-24-15 failed to evidence the SN had applied the silver dressing to the wound bed as ordered by the physician. 3. Clinical record number 3 identified the patient as a 69 year old with diagnoses of open wounds of the right forearm and right leg, COPD (chronic obstructive pulmonary disease), and congestive heart failure. The record included plans of care established by the physician for the certification periods 10-22-15 to 12-20-15 and 12-21-15 to 2-18-16. The plans of care state, "SN to obtain weight once a week and notify MD of a gain or loss of 2 lbs within a week. SN to do dressing change to Rt [right] lower leg, Lt [left] lower leg, Lt forearm, Rt forearm wounds."	{N 537}		

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{N 537}	Continued From page 16 A. SN visit notes, dated 12-2-15, 12-4-15, 12-7-15, 12-9-15, 12-11-15, 12-14-15, 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence the SN had obtained the patient's weight at any of the visits. B. SN visit notes, dated 12-2-15, 12-4-15, 12-7-15, 12-9-15, 12-11-15, 12-14-15, 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence any wound care had been provided to the patient's left lower leg. 4. The administrator was unable to provide any additional documentation and/or information when asked on 1-4-16 at 3:00 PM. 5. The agency's undated "Scope of Services" policy number III-2 states, "Professional nursing services shall be performed in accordance with the attending physician's plan of treatment."	{N 537}		
N 541	410 IAC 17-14-1(a)(1)(B) Scope of Services Rule 14 Sec. 1(a) (1)(B) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (B) Regularly reevaluate the patient's nursing needs. This RULE is not met as evidenced by: Based on record review and interview, the agency failed to ensure updates and revisions to the comprehensive assessments were complete in 2 (#s 1 and 2) of 3 records reviewed. The findings include:	N 541		

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N 541	Continued From page 17 1. Clinical record number 1 included a follow-up comprehensive assessment dated 11-13-15. The assessment identifies the patient has a cough that is "acute" and "chronic" with "thick, white" secretions that "require suctioning" and "suctioning necessary". The assessment failed to to evidence how often the suctioning is required and how the patient tolerates the procedure. A. The assessment identifies the patient has a gastrostomy tube for nutrition and receives bolus feedings. The assessment failed to evidence the type of feedings and the number of feedings per day. B. The assessment identifies the patient is unable to vocalize and makes eye contact. The assessment failed to evidence communication patterns and methods used to relate to the patient. C. The assessment failed to evidence an assessment of the home environment. The home environment safety portion of the assessment had been left blank. 2. Clinical record number 2 included a follow-up comprehensive assessment dated 12-4-15. The assessment failed to evidence an assessment of the patient's throat. This had been left blank. A. The assessment identifies the patient performs in and out self-catheterization. The assessment failed to identify the type of catheters used, the usual amount obtained, or any issues with the self-catheterization. B. The assessment identifies the patient has a "colostomy". The assessment failed to evidence any detatils about the colostomy.	N 541		

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N 541	Continued From page 18 C. The assessment failed to evidence an evaluation of the patient's psychosocial status. This portion of the assessment had been left blank. D. The assessment identified the patient has a "port". The assessment failed to evidence an evaluation of the port. 3. The administrator was unable to provide any additional documentation and/or information when asked on 1-4-16 at 3:00 PM.	N 541		
{N 542}	410 IAC 17-14-1(a)(1)(C) Scope of Services Rule 14 Sec. 1(a) (1)(C) Except where services are limited to therapy only, for purposes of practice in the home health setting, the registered nurse shall do the following: (C) Initiate the plan of care and necessary revisions. This RULE is not met as evidenced by: Based on record review and interview, the registered nurse failed to initiate a revision to the plan of care to address a change in the patient's condition in 1 (#3) of 3 records reviewed. The findings include: 1. Clinical record number 3 identified the patient as a 69 year old with diagnoses of open wounds of the right forearm and right leg, COPD (chronic obstructive pulmonary disease), and congestive heart failure. The record included a plan of care established by the physician for the certification period 12-21-15 to 2-18-16. The plan of care states, "SN to do dressing change to Rt [right]	{N 542}		

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{N 542}	Continued From page 19 lower leg, Lt [left] lower leg, Lt forearm, Rt forearm wounds." A. The follow-up comprehensive assessment dated 12-16-15 failed to evidence an assessment of a wound on the patient's left leg. B. SN visit notes, dated 12-16-15, 12-18-15, 12-22-15, 12-23-15, and 12-30-15 failed to evidence any wound care had been provided to the patient's left lower leg. 2. The administrator stated, on 1-4-16 at 3:15 PM, "The wound [on the left leg] may have been healed." 3. The agency's undated "Scope of Services" policy number III-2 states, "Skilled Nursing Services . . . Professional nursing services shall be performed in accordance with the attending physician's plan of treatment and shall include but not be limited to: Assessment and regular reassessment of the nursing needs of the client throughout the course of care . . . Notification of physician of client progress."	{N 542}		